A MATTER OF PRIORITIES*

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At the time this program was organized, the heart had not yet been cut out of the New York State Medicaid program. It was still possible, in many institutions such as my own and similar ones, to plan realistic time tables for day clinic reorganization, for night clinics, for group practice and group coverage of emergency rooms, and for neighborhood satellite clinics. Mary C. McLaughlin's report sharply indicates that current attempts to organize adequate health services in New York City represent a vivid exercise in futility; from a similar point of view are not many programs and proposals discussed at this conference, as a whole, also such an exercise? In this regard, I must stress just one figure presented here: 30 million Americans are classifiable as poor, with all that signifies in problems of adequate health care.

There is unfortunately no donor in sight to permit transplanting or replanting the heart which has been cut out of financial assistance to medical care, nationally as well as locally.

What is new about our session here? In 1931, 37 years ago, the problems we are discussing were analyzed in depth by a special commission, the Committee on the Cost of Medical Care; and among specific recommendations made by that commission was one calling for the organization and expansion of group practices in answer to the needs for the medical care of the future. I repeat, that was 37 years ago.

I fear the major problem is, perhaps, that we are skirting the real issue. We are skating around it, we are avoiding it, consciously on the part of some, unconsciously, probably, on the part of most.

The basic issue is best noted in the action of the New York State legislature which, several weeks after effectively crippling the Medicaid program for lack of funds, voted itself a handsome new pension scheme; apparently there was no lack of funds for that.

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It is seen by the alacrity with which our Congress finds additional funds, amounting to billions, to pursue horrendous military actions in Asia which have not redounded to our nation's advantage, to put it mildly; and the *deliberate* speed (deliberate *not* in the sense of the Supreme Court) with which the same Congress cuts funds allocated to manifold health and welfare services, beginning with health.

What therefore is this basic issue? I submit that it is that of the priorities that our society is willing to live with, at least as they are demonstrated by the programs visible on the national, state, and local scenes. We appear to be able to organize a miracle of speedy rescue transport services, to transport by helicopter a wounded soldier in minutes from a battlefield to a field hospital some miles away to save his life, and properly so. Yet we cannot organize services to provide efficient, speedy ambulance systems to transport critically ill adults and children from their homes to nearby hospitals. Are these people not "wounded" also? Perhaps by illness, if not by a bullet or bombs.

I need not labor the point for this audience. Where, in our society's scale of priorities, of what *is* important and what *is not* important, lies health? I submit that here is where "lies the rub"—not only in the priority of health care but of general social services for Americans.

How many "Columbia Point" projects are required to provide adequate care in Boston? How many "Gouverneur" and Demonstration Neighborhood Family Care Clinics to do the same in New York City? How many "Watts" clinics to do likewise in Los Angeles? How many clinics in Chicago, similar to those Joyce C. Lashof has described? In short, how many in America and in our major cities as a whole, not to speak of the rural areas to which John W. Hatch referred?

At my own medical center in Brooklyn there is a remarkable Community Mental Health Center in operation, one of the first and one of the finest in the East. It is organized to serve 100,000 people with a comprehensive program of mental health services. This National Institute of Mental Health program calls for about 40 such centers in New York City alone, at the ratio of about 100,000 people for each one.

In view of our scheme of national priorities, how and when can any of this be achieved within any reasonable time scale?

During the past few days we have been hearing a lot about the organization of group medicine and group medical practices. Where are these groups to come from?

Dr. McLaughlin in her paper has asked a host of questions, all of which are pertinent and, I submit equally strongly, all of which are, in the final analysis, *un*answerable within the scale of priorities accorded these problems in our society today.

Why must it require a national, or rather an international tragedy, to get the recent Civil Rights Bill passed and a strike settled? Must it take similar tragedies to alter the priorities assigned to our nation's health and social welfare?

I am reminded of Heywood Broun's picturesque definition of the characteristics of a conservative, liberal, and radical which he wrote many years ago. Broun drew a word picture of a man watering a lawn with a hose that had many holes. As he put it, the conservative keeps on watering despite the leaks because some water manages to dribble out the front end of the hose and, if he keeps at it long enough, he will finally have the lawn somewhat watered. The liberal drives himself frantic taping up the old holes and the new ones as fast as they appear, paying little attention to what comes out at the end. The radical looks at the hose, says "the hell with it," throws the hose away, goes to the local hardware store and buys a new one.

The Committee on Costs of Medical Care has met in Washington, D. C., and issued its report. The Conference on Group Practice met in Illinois in October of last year and issued its report. The President's Commission on Health Manpower met recently and issued its paper. The Millis Committee of the American Medical Association met and issued its report on the training and organization of postgraduate education for the physician of tomorrow. I am sure that at the end of our conference our reports will be assembled and issued in due time.

All of these reports have identified the leaks in the hose. They can be translated in health care terms (using cliches, perhaps, but most cliches are self-evident truths, are they not?) as care that is episodic, fragmented, discontinuous, crisis-oriented, and that inhibits preventive care and contains, as presently organized, above all, a built-in cost-escalation factor that is unavoidable. I think that this applies generally across the board and not only to the health care available to people in ghetto and poverty areas. The health product coming out at the end of the hose permits us to be 11th in perinatal mortality among the world's nations; it obliges us to import medical manpower from countries which can least spare medical personnel to meet our own shortages; it makes us

build a complete rationale and a theory (and I find *this most* fascinating) about the virtues of "auxiliary medical manpower" and the creation of a "feldscher" type of system to meet our manpower shortage.

When the Soviet Union (and I am aware it causes problems when one cites it as an example) is phasing out its feldscher system and is exporting physicians around the world, I question whether we are moving forward, or *rationalizing* and *institutionalizing* a step backward.

Is it time, perhaps, to raise a basic question at such gatherings? That we take a *close, hard* look at our *system* of providing health services, or rather precisely our *lack* of system in providing these services and, like Heywood Broun's radical, throw the leaky hose away and get us a new one. Unfortunately, we do not have a corner hardware store where we can buy it, and this will not be easy to do.

But several steps are possible as a beginning.

First: meetings such as this must change from problem-identifying sessions and demonstration sessions and become—horrible phrase—action-oriented, with the formulation of specific and detailed programs that can then be fought for with all conceivable pressures that the concentrated talent assembled here can generate.

Second: these pressures must be fused with those arising from the consumers of health services *especially*, but—I must emphasize—not *only* from the ghetto and slum areas because this problem cuts across our entire national scene. These pressures must be concentrated upon government and health care facilities and agencies for more effective and comprehensive programs.

Third: the problem of priority can be solved *best* by such a partnership of the providers and consumers of health services.

The time is more than ready for the health care professionals—physicians, nurses, technicians, and social workers, among others—to break out of their isolation and, by uniting their efforts with the consumer, work toward the achievement of socially more useful priorities and for fundamental changes in our system of health care services.

Several timid steps appear to have been taken. Is not the telegram addressed to the governor of New York State sent from this conference to protest the cut in Medicaid such a step? The Health and Hospital Planning Council has called an emergency meeting to organize a community protest. But these are only beginnings. More, much more will be required if the problems discussed at this conference are to be solved.

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